AHIP Testimony on SB 204
Connecticut Insurance and Real Estate Committee – March 1, 2012

I am Brian Quigley, Regional Director for America's Health Insurance Plans. AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of insurance products, including major medical, long term care, disability income, dental, vision, specified disease and other supplemental coverages. I appear today for the Connecticut Association of Health Plans to indicate our strong opposition to Senate Bill 204, An Act Concerning The State Medical Loss Ratio.

Connecticut has competitive individual and small group markets. Unlike many of the surrounding states, which have chosen to excessively regulate the individual market, Connecticut has had a relatively stable, more affordable individual market, despite high health care costs similar to its neighboring states. According to a recent AHIP survey of our members, the average annual single premium for an individual product in Connecticut was $3503. In New York, with more restrictive rating and underwriting rules, it was $6630, $3127 more. In Massachusetts, $5143, $1640 more.

More restrictive and cumbersome regulatory environments do not result in cheaper coverage. They destroy innovation in product development, discourage participation in the market and create a dysfunctional market. Where carriers see a regulatory environment that is significantly more cumbersome than other states, product innovation stops and products with increasing cost sharing become the norm.

With the development of the Exchange, the state should want to encourage carriers to participate in the market, not drive them away.

The new federal MLR requirements on health plans create higher administrative costs due to a variety of new reporting and compliance activities that go far beyond what plans previously were required to undertake. This has necessitated the creation of new information technology systems, contracts, and administrative compliance centers to address and manage the complexity of the new requirements. Plans have made these changes in the context of an 80% MLR requirement in the individual and small group markets. To increase that requirement essentially before it has even had a chance to work is premature and very disruptive.

Comparisons to the 82% MLR standard in New York can be very misleading. The regulatory environment is very different in New York, with guaranteed issue and community rating in the individual market. This results in higher medical costs. While this may make it easier to meet the higher MLR requirement, it also means that premiums in New York are significantly higher than in Connecticut and coverage options are much more limited.

The 82% standard in New York is not based on NAIC standards, as some have claimed. The NAIC did not address that issue since it was stated in the federal law.

The $114.5 million in refunds in 2011 under the New York law represent reimbursements on 2010 rates, which were filed in 2009 -**before** the prior approval law and the new higher 82 percent MLR standard were put in place. It was enacted in June, 2010 retroactive to January of 2010, well after rates were in the market place under the previous lower MLR standard of 75%. This retroactive application is what triggered large rebates. By contrast, the federal MLR standards and requirements also passed in 2010 but they are only being implemented in 2012 on 2011 rates, giving health plans the opportunity to properly price their products and make appropriate changes to their administrative costs.

A higher MLR does not mean there will be less expensive coverage. New York and Massachusetts have higher MLR requirements and, as pointed out above, their premiums are significantly higher than those in Connecticut in the individual market. This is no surprise, since an MLR requirement does nothing to

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address the real drivers of premium increases: soaring prices for medical services, costly new medical technologies, changes in the covered population, and the impact of new federal benefit and coverage mandates.

In considering the appropriateness of a higher MLR standard, states are obligated under the federal MLR rules to take into consideration whether such a change will ensure adequate market participation, competition in the market and value for consumers. It is premature to increase the MLR standard before the first federal MLR reports are submitted this June and before a proper study of the market impacts can be made using the results of those reports.

The changes to the definitions in Senate Bill 204 may introduce factors that are inconsistent with federal requirements and they will be preempted. New York recently recognized this problem under their law and the New York Department of Financial Services issued a Circular Letter indicating that the HHS MLR rule makes it clear that insurers would need to use the federal MLR definitions and calculation.

States do not have the authority to alter those definitions or methodologies. In guidance issued in May, 2011, HHS stated " ***A State may not propose an adjustment to how the MLR is calculated. By way of example, a State may not propose definitions or methods for calculating the MLR that differ from those established by the federal law and regulations."***

The 80% MLR standard was included in the federal law after over a year of careful deliberation. The definitions and factors in the federal MLR rule were developed over an equally long and deliberative process. There is no reason for Connecticut to try a different approach. It will only drive up the cost of writing coverage in Connecticut and force carriers to consider whether it makes sense to continue to compete in this market.

Imposing a higher MLR requirement has major potential to disrupt a market that is working. We urge you to oppose Senate Bill 204.

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